HEALTH FINANCE COMMISSION

Legislative Services Agency
200 West Washington Street, Suite 301
Indianapolis, Indiana 46204-2789
Tel: (317) 232-9588 Fax: (317) 232-2554

MEETING MINUTES[1]

Meeting Date:	**August 25, 1999**
Meeting Time:	**1:30 P.M.**
Meeting Place:	**State House, 200 W. Washington St., Room 404**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**1**

Members Present: **Rep. Charlie Brown; Rep. Brian Hasler; Rep. William Crawford; Rep. Susan Crosby; Rep. John Day; Rep. Win Moses; Rep. Peggy Welch; Rep. Vaneta Becker; Rep. Robert Behning; Rep. Mary Kay Budak; Rep. Gloria Goeglein; Sen. Billie Breaux; Sen. Earline Rogers; Sen. Vi Simpson; Sen. Kent Adams; Sen. Beverly Gard; Sen. Steve Johnson; Sen. Connie Lawson; Sen. Patricia Miller.**

Members Absent: **Rep. Craig Fry; Rep. Timothy Brown; Rep. David Frizzell; Sen. Allie Craycraft; Sen. Greg Server; Sen. Marvin Riegsecker.**

Senator Patricia Miller, Chair of the Commission, called the meeting to order at approximately 1:40 p.m. After the introduction of Commission members, staff described the charges to the Commission (Exhibit 1). According to IC 2-5-23-4, the Health Finance Commission may study any topic: (1) directed by the Chairman of the Commission; (2) assigned by the Legislative Council; or (3) concerning issues that include either the delivery, payment, and organization of health care services or rules adopted under IC 4-22-2 that pertain to health care delivery, payment, and services that are under the authority of any board or agency of state government. In addition to the statutory charge, staff indicated that the Legislative Council (in Legislative Council Resolution 99-1) assigned the following topic to the Commission: to study the need for a comprehensive long term care plan.

[1]Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is http://www.ai.org/legislative/. No fee is charged for viewing, downloading, or printing minutes from the Internet.

Concept of Medical Necessity

Mr. Jim Zieba - Indiana State Medical Association (ISMA)

Mr. Jim Zieba, ISMA, discussed the concept of medical necessity and its implementation. Mr. Zieba presented the American Medical Association's definition of medical necessity (Exhibit 2) as the following: "Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (1) in accordance with generally accepted standards of medical practice; (2) clinically appropriate in terms of type, frequency, extent, site, and duration; and (3) not primarily for the convenience of the patient, physician, or other health care provider." Mr. Zieba did, however, indicate that this was not necessarily the ISMA's position. Mr. Zieba also indicated that there has been a drive in recent years to have a definition for medical necessity in statute in order to provide more uniformity among insurance companies in their coverage decisions. Mr. Zieba contended that medical necessity should be determined by the health care provider and that there can be problems associated with putting the definition in writing and into statute, potentially eliminating the use of some treatments. He further added that it is important for patients to know what is covered by their insurance or health plan and that cost should never be part of the medical necessity decision.

Mr. Zieba, responding to a question from the Commission, indicated that medical necessity is not currently defined in Indiana statute, but is in the Medicaid program regulations.

Mr. Zieba, responding to a question from the Commission, indicated that there is a high priority for patient satisfaction in the implementation of the medical necessity decision. However, the question becomes how is the best way to ensure patient satisfaction: through physician choice or through a statutory definition. Mr. Zieba also responded that the major impetus for defining medical necessity over the last couple of years has come from patients over concerns about coverage.

Mr. Ron Wuensch, Indiana Optometric Association added that the medical necessity determination not only affects coverage, but also the question of where care is given.

Commission members indicated that they would like information provided on what other states are doing in terms of the medical necessity issue.

Sam Cramer, M.D., - Anthem Blue Cross/Blue Shield of Indiana

Dr. Sam Cramer, Medical Director, Anthem Blue Cross/Blue Shield of Indiana, discussed medical necessity from the perspective of the insurance industry. Dr. Cramer stated that when a case comes in for review, the case is considered from several angles: (1) *Benefit Coverage* - whether the procedure or condition is actually covered by the policy as selected or chosen by either the consumer or employer; (2) *Medical Policy* - often involves the appropriateness of new technologies and is based on the scientific evidence currently available. Medical policy is used primarily for the protection of the consumer and is determined by a board of physicians; and (3) *Medical Necessity* - Medical necessity is the issue of doing the right procedure at the right time and at the right place.

Dr. Cramer described the process as the following: If there is a question on coverage by the initial reviewer, the question is put before a physician for review. The reviewing physician is employed by the plan or a consulting physician or panel. The procedure in question can be approved at this point. If there are any questions, the reviewer contacts the attending physician. Denial rates are about 3%. If denied, there is an appeal mechanism. There is also

an audit procedure in place reviewing the decisions, themselves, what approvals and denials were made, what medical procedures were used, and whether the decisions were outside of established norms. Dr. Cramer indicated that it is very important that there be contact with the attending physician. This often results in a change in the decision of what treatment is most appropriate.

Dr. Cramer added that carriers are under a set of standards for the conduct of medical review, as well as bound by accrediting bodies that have guidelines for reviews and appeals. He added that there are also guidelines in the HMO and insurance code.

Dr. Cramer related that he grew up in an era of old-fashioned utilization management where everything was under prior authorization. The industry has tended to move away from this, but it is still a hard sell to convince his accounts to eliminate prior authorization. In fact, sometimes it makes sense to provide a benefit, even if the policy does not provide coverage, in order to save costs in the long term. Dr. Cramer stated that he would like to move to an era of "up-front case management" where patients are identified early as being at-risk of worse conditions later and, thus, prevent bigger problems at a future time.

Responding to a question from the Committee, Dr. Cramer stated that, since medical technology changes so rapidly, defining "medical necessity" in statute might actually hurt consumers by eliminating some possibilities for treatment.

Responding to a question, Dr. Cramer stated that some reviews are conducted on-site, depending upon the patient volume of the hospital and insurance plan at the site.

Ms. Kathy Gifford - Office of Medicaid Policy and Planning (OMPP)

Ms. Kathy Gifford, Assistant Secretary for OMPP, provided to the Committee a document (Exhibit 3) describing the regulatory definition under which the state Medicaid program operates, selected prior authorization (PA) statistics, and a diagram describing the prior authorization medical necessity decision process.

Ms. Gifford stated that OMPP as a practice would rather check (on the back end) whether there had been overutilization and do less prior authorization. She added that non-medical staff can approve claims, but if there is a medical question, the question must go before a medical consultant. She also noted that prior authorization decisions are appealable.

Responding to a question about Exhibit 3 as to why mental health services have the lowest percentage of approvals, Ms. Gifford stated that it may just be due to the type of procedures requiring PA, such as admissions and number of days, etc. Members stated that they would like add additional information on PA for mental health services.

Responding to a question as to why Anthem was reported to have a denial rate of about 3% and Medicaid had a denial rate of 29%, Ms. Gifford stated that the Medicaid denial rate also includes duplicates, eligibility denials, etc.. Committee members stated that they would also like to have clearer and more precise data.

Health Professions Licensure

Ms. Laura Langford - Health Professions Bureau

Ms. Laura Langford, Executive Director of the Health Professions Bureau, provided a folder of information (Exhibit 4) to the Committee. The folder included an overview of the Health Professions Bureau, a description of the initial licensure process, and a description of the

license renewal process. Ms. Langford also provided to the Committee an application form for license renewal.

Ms. Langford stated that the average time for license renewals takes 4 to 6 weeks, while physician license renewals takes about 8 weeks. She added that with additional cross-training and internet usage, she was hoping that lag times could be improved.

Responding to a question about license fees, Ms. Langford stated that the $40 fee is deposited into the state General Fund. Collections currently are around $2 million per year. Previous to fees being lowered in 1996, fee collections were around $4 million annually.

Responding to a question, Ms. Langford stated that the Health Professions Bureau does not conduct investigations. Investigations are conducted through the Office of the Attorney General.

Mr. Jim Zieba - Indiana State Medical Association

Mr. Jim Zieba, Indiana State Medical Association, provided a handout to the Committee (Exhibit 5). The handout included internet and newspaper articles describing problems experienced by physicians in renewing their licenses, as well as some letters from individual physicians.

Mr. Zieba explained that physician license renewal must occur every two years before June 30. In previous years, his office had received many phone calls because the physicians had not received renewal notices and applications. In 1999 his office started receiving calls and complaints, again. Mr. Zieba then related the experiences of two individual physicians. Problems that were encountered included being listed incorrectly by the Bureau as having moved, and the inability to apply for a license renewal by walking into the Bureau's office.

Responding to a question as to when acceptance of walk-ins was stopped, Ms. Langford replied that the practice was discontinued in 1996.

Responding to a suggestion by the Committee that, perhaps, staggering the renewal process should be considered, Ms. Langford indicated that with 23 professional boards under the jurisdiction of the Bureau, the process is already staggered.

Responding to a question, Ms. Langford stated that not very many license renewal applications are denied. The Committee requested that the Bureau provide data on the number and cause of denials for the last five renewal cycles.

The Committee suggested that it may be time to rethink the issue of licensing and renewals.

Mr. Zieba stated that physicians really don't have a problem with the fee level, but just want to receive the appropriate services. Mr. Zieba added that the fees should stay with the Health Professions Bureau rather than go to the state General Fund.

Ms. Naomi Patchin - Indiana State Nurses Association

Ms. Naomi Patchin, Executive Director of the Indiana State Nurses Association, provided written testimony (Exhibit 6) to the Committee. Ms. Patchin indicated that her association does not believe that the $17 license fee paid by nurses is too high, but that the money that is collected should be used to provide services and perform necessary work. She also stated that the license fees are deposited into the state General Fund and the legislature decides on the Bureau's budget. The Bureau is often asked to revert part of their budget.

She stated that individuals who apply for new licenses, renew licenses, or request other services pay fees that should pay for the operations of the Bureau. They would be willing to pay more to have the services available in a timely and accurate manner, but would be unwilling to pay more to have the money go to the General Fund.

Ms. Patchin indicated that during the 1997 license renewal, some registered nurses did not receive their licenses by the renewal date. Consequently, they had to take time off from work without pay.

Ms. Patchin also claimed that the statute that requires the State Board of Nursing to "collect and distribute annually demographic information on the number and type of registered nurses and licensed practical nurses employed in Indiana" is not being followed. This information was collected in 1997, but no survey has been conducted since.

Ms. Patchin indicated the nurses want the following: (1) Prompt and courteous responses to questions and requests; (2) An agency that can respond to situations with the least amount of bureaucracy and with common sense; (3) A Board of Nursing that has sufficient and appropriate staff to assist them; and (4) Accurate and timely demographic data. She also indicated that the Bureau would be well served by establishing a routine formal mechanism to review how well the Bureau serves the public.

Responding to a question, Mr. Ron Wuensch, representing the Indiana Podiatric Medical Association, indicated that podiatrists have a four-year license renewal cycle.

Committee members suggested that the Committee should consider recommending: (1) a grace period of perhaps 60 days; and (2) the boards administered by the Health Professions Bureau move to four-year license renewal cycles.

The date for the next meeting of the Commission was determined to be Monday, September 20, 1999, at 10:30 a.m. in Room 404 of the State House. The principal agenda topic for the next meeting will be the issue of long term care.

There being no further business to conduct, the meeting was adjourned.